MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

Sample

PERSON REGISTERING THE COMPLAINT

Please Print or Type

☑ Mr. ☐ Ms.
Name: Doe (Last Name) Jerry (First Name) L. (M.I.)

Mailing Address: 2005 Evergreen Street, Suite 1200

Sacramento (City) CA (State) 95815 (Zip)

Phone Number: (916) 999-9999 (Daytime Number) (916) 999-9999 (Evening Number) (Cell phone/E-mail address)

☐ Mr. ☑ Ms.
Patient Name: Doe (Last Name) Jane (First Name) K. (M.I.)

Patient Date of Birth: 06-23-1948 **Your Relationship to Patient:** Husband

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

☑ **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

☐ **Prescribing Issues** (e.g., excessive/under prescribing, Internet)

☐ **Unlicensed Provider orAiding/Abetting unlicensed practice**

☐ **Sexual Misconduct**

☐ **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)

☐ **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

☐ **Office Practice** (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other_____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:

☑ **Physician (M.D.)** ☐ **Podiatrist (DPM)** ☐ **Physician Assistant (PA)** ☐ **Registered Dispensing Optician (RDO)** ☐ **Midwife** ☐ **Unlicensed Provider**

COMPLAINT REGISTERED AGAINST **Please Print or Type**

Name: Blake (Last Name) J. (First Name) B. (M.I.)

Office/Facility Name: San Mateo Med Clinic **License No.** (If known): A55555

Street Address: 1234 San Mateo Drive (Address) San Mateo (City) CA (State) 94056 (Zip Code)

Phone Number: (650) 999-9122

Has the patient been examined/treated by another professional for this same condition?

☐ **No** ☑ **Yes** **If yes, provide name and address on the Authorization for Release of Medical Information**

Reason for Treatment: Heart Problems

Date(s) of Treatment: January 2003 through March 2005

DETAILS OF COMPLAINT

(Attach additional sheets if necessary)

Jane had been suffering from angina, difficulty breathing and swelling feet. Dr. Blake said it was due her weight and irregular heart beat. He never did any extensive tests. We went to Dr. Blond who did several tests after Jane did not get better. He diagnosed Jane with congestive heart failure.

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
2005 Evergreen Street, Suite 1200, Sacramento, CA 95815

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name *Doe*	Date of Birth *06-23-1948*
Medical Record Number (If applicable) *222244*	Date of Death (If applicable) *01-01-2000*
Control Number	Social Security No. (Optional) *999-99-9999*

I, the undersigned hereby authorize:

Physician/Facility *Blake*

Address *San Mateo Med Clinic, 1234 San Mateo Blvd.*

City/State/Zip Code *San Mateo, CA 94056*

Phone Number(s) *(650) 999-9122*

Treatment Date(s) *January 2003 - March 2005*

to disclose medical records in the course of my diagnosis and treatment to the **Medical Board of California, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Medical Board of California at the above address. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

Patient Signature _____ Date _____
or Legal Representative _____ Date _____
Relationship

NOTE: Failure by a physician, podiatrist or health care provider to provide the requested records within 15 days, or a health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.